Medwork Independent Review
5840 Arndt Rd., Ste #2
Eau Claire, Wisconsin 54701-9729
1-800-426-1551 | 715-552-0746
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ACCREDITED INDEPENDENT REVIEW ORGANIZATION

NOTICE OF MEDWORK INDEPENDENT REVIEW DECISION
Workers' Compensation Health Care Non-network (WC)

DATE OF REVIEW: 7/9/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE
Spinal cord stimulator trial for lumbar radiculopathy, disc disease

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION
Texas State Licensed DO Board Certified Physical Medicine & Rehabilitation physician

REVIEW OUTCOME [PROVIDE FOR EACH HEALTH CARE SERVICE IN DISPUTE]
Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)
☐ Overturned (Disagree)
☐ Partially Overturned (Agree in part/Disagree in part)
Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW
1. Texas Dept of Insurance Assignment to Medwork 6/20/2012,
2. Notice of assignment to URA 6/19/2012,
3. Confirmation of Receipt of a Request for a Review by an IRO 6/20/2012
4. Company Request for IRO Sections 1-4 undated
5. Request For a Review by an IRO patient request 6/19/2012
6. Response to request for IRO from Attorneys 6/22/2012, letter from attorney 6/19/2012, explanation of review 6/15/2012, explanation of review 5/19/2012, medical records 5/17/2012, letter from 5/4/2012, medical records 5/3/2012, 4/27/2012, 4/25/2012, 4/23/2012, 4/19/2012, 4/3/2012, letter from 4/9/2012, medical records 4/9/2012, 3/26/2012, 3/22/2012, 2/29/2012, 5/26/2011, 4/26/2011, 8/23/2010, 8/20/2010, 7/6/2010

PATIENT CLINICAL HISTORY:
The patient is a female who sustained an occupational lower back injury of xx/xx/xx. The patient remains symptomatic with lower back pain and associated bilateral lower extremity radicular pain, more prominent on the right. The lumbar MRI scan demonstrates L4-L5 and L5-S1 degenerative disk disease. A subsequent April 26, 2011, lumbar MRI scan was essentially unchanged. The patient had failed an August 20, 2010, L5-S1 fluoroscopic lumbar epidural steroid injection. The patient had also failed physical therapy and chiropractic treatment.

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Physical examination findings of the patient indicate focal right lateral calf sensory impairment with normal lower extremity deep tendon reflexes.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

According to ODG guidelines, the spinal cord stimulator trial is recommended only for selected patients unless invasive procedures have failed or are contraindicated. According to ODG guidelines, "there is some evidence supporting the use of spinal cord stimulation (SCS) for failed back surgery syndrome (FBSS) and other selected chronic pain conditions. Spinal cord stimulation is a treatment that has been used for more than 30 years, but only in the last 5 years has it met with wide spread acceptance and recognition by the medical community. In the first decade after its introduction, SCS was extensively practiced and applied to a wide spectrum of pain diagnoses, probably indiscriminately. The results at follow-up were poor and the method soon fell in dispute. In the last decade, there has been growing awareness that SCS is a reasonably effective therapy for many patients suffering from neuropathic pain for which there was no alternative therapy."

According to ODG guidelines indications for stimulator implantation are listed as failed back syndrome when all of the following are present: symptoms primarily involving lower extremity radicular pain but limited response to non-interventional care, psychological clearance and no contraindication to the trial. According to the submitted medical information reviewed the patient is demonstrating MRI scan findings supportive of L4-L5 and L5-S1 degenerative disk disease; however, the patient is not considered an operative candidate. The patient has received ongoing palliative medication management. However, the patient has failed lumbar epidural steroid injections. The patient does not satisfy the ODG guideline criteria for spinal cord stimulator trial and therefore this request remains non-certified; therefore, the insurer's denial is upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ **ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE**
- ☐ **AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES**
- ☐ **DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES**
- ☐ **EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN**
- ☐ **INTERQUAL CRITERIA**
- ☒ **MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS**
- ☐ **MERCY CENTER CONSENSUS CONFERENCE GUIDELINES**

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- ☐ **MILLIMAN CARE GUIDELINES**
- ☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**
- ☐ **PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR**
- ☐ **TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS**
- ☐ **TEXAS TACADA GUIDELINES**
- ☐ **TMF SCREENING CRITERIA MANUAL**
- ☐ **PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)**
- ☐ **OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)**